U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 April 2007

Case No. 2005-BLA-5756

In the Matter of

B. B.,

Claimant,

v.

RATLIFF & CHILDERS COAL CORP.

Employer,

and

LIBERTY MUTUAL INSURANCE GROUP,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:[1]

Stephen A. Sanders, Esq.
Appalachian Citizens Law Center
Prestonsburg, Kentucky
For the Claimant

[1] The Director, Office of Workers' Compensation Programs, a party in this proceeding, was not present or represented by counsel at the hearing. By failing to appear at the hearing or participate in this case after referral to this office, the Director is deemed to have waived any issue which it could have raised at any stage prior to the close of this record. By referring this matter for hearing, the District Director is further deemed to have completed evidentiary development and adjudication as required by the regulations. 20 C.F.R. § 725.421.

Francesca Maggard, Esq.
Lewis and Lewis Law Firm
Hazard, Kentucky
For the Employer

BEFORE: LARRY S. MERCK
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 ("Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On April 13, 2005, this case was referred to the Office of Administrative Law Judges by the District Director, Office of Workers' Compensation Programs ("OWCP"), for a hearing. (DX 36).[2]

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

5. Whether Claimant's disability is due to pneumoconiosis; and,

[2] In this Decision and Order, "DX" refers to Director's Exhibits, "CX" refers to Claimant's Exhibits, "EX" refers to Employer's Exhibits, and "TR" refers to the transcript of the hearing.

[3] At the hearing, Employer withdrew the following contested issues: miner, dependency, and responsible operator. (TR 11-12). In addition, Employer and Claimant stipulated to 33.5 years of coal mine employment. *Id.* Employer also maintains an issue for appellate purposes only. (TR 12).

6. Whether the evidence establishes a material change in conditions per § 725.309(d).[4]

(DX 36).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

Claimant was born on September 2, 1932, and has an eighth grade education. (DX 3). He is married and has no dependent children. (DX 4).

Claimant primarily worked as a truck driver hauling rock. (DX 2, 4-6; TR 16-21). He also drilled and shot coal, operated an auger, and worked on a tipple. (DX 2, 4-6; TR 18-26). He was exposed to significant amounts of coal dust in the aforementioned jobs. (DX 2, 4-6; TR 16-26). In 1985, Claimant ceased coal mine employment due to shortness of breath and an ear injury. (DX 3).

Claimant reported that he is short of breath and can no longer walk long distances. (DX 3). He also testified that he can no longer do any yard work or gardening. (TR 28). He can only climb one or two stairs at a time before stopping to catch his breath. (TR 29). During the daytime, Claimant uses a nebulizer to help him breathe, and on some days he uses oxygen. (TR 30). He also stated that he must sleep using extra pillows to prop himself up to keep from smothering. (TR 29). He also uses oxygen every night. *Id.*

Claimant testified that he started smoking cigarettes when he was a teenager and that he quit smoking in the early 1980's, before he quit his job as a coal miner. (TR 28, 33). When asked why he quit smoking, Claimant replied that it was "hurting [him] more than it [was] helping [him]." (TR 33). Claimant stated that he sometimes smoked as much as half a pack of cigarettes a day. (TR 28). Dr. Forehand recorded that Claimant smoked a half a

[4] Although not marked on the CM-1025, this is a subsequent claim and will be analyzed as such. (DX 1, 3, 36).

pack of cigarettes a day from 1944 to 1974. (DX 15). Dr. Baker noted in his medical report that Claimant smoked a half a pack to a pack of cigarettes a day, off and on for fifteen to twenty years, beginning in the 1960's and quitting in the 1980's. (CX 1). Dr. Stamper, Claimant's treating physician since 1978, did not record Claimant's smoking history on the questionnaire that he filled out, which Claimant submitted as evidence. (DX 13). Dr. Dahhan reported that Claimant smoked a half a pack to a pack of cigarettes a day, beginning at age sixteen and quitting at age fifty. (DX 28). Dr. Fino, reported that Claimant smoked one pack of cigarettes a day for forty-one years, from 1943 to 1984. (EX 1). In his medical report, in which he reviewed all of the medical evidence in the record, Dr. Fino also recorded that Claimant reported smoking one pack of cigarettes a day for twelve years, quitting twenty years earlier. *Id.* I find that the preponderance of the evidence establishes that Claimant has a fifteen to twenty pack-year smoking history.

Besides his breathing problems, Claimant has also had problems with his heart and ears. (TR 32). In addition, he also had colon cancer. (TR 31). In 2006, Claimant underwent chemotherapy and radiation treatment for cancer in his left lung. *Id.* Claimant is prescribed several medications for his breathing problems, including continuous oxygen, as discussed above. *Id.*

Claimant filed his first claim for benefits on May 22, 1987. (DX 1). Administrative Law Judge Bernard J. Gilday, Jr., found that Claimant had established thirty-three and a half years of coal mine employment, but denied the claim on March 10, 1989, finding that Claimant had failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(1-4). *Id.* Claimant appealed, and the Board affirmed Administrative Law Judge Gilday's determination as to the length of Claimant's coal mine employment, as well as his findings that Claimant had not established pneumoconiosis under § 718.202(a)(1-3), but vacated his findings under § 718.202(a)(4) and remanded the case. (DX 1)(citation omitted).

On remand, Administrative Law Judge Gilday continued to find that Claimant had not proved the existence of pneumoconiosis under subsection (a)(4), and denied benefits accordingly. (DX 1). Claimant appealed again, but this time the Board affirmed Judge Gilday's finding that Claimant did not establish the existence of pneumoconiosis pursuant to § 718.204(a)(4). (DX 1)(citation omitted).

On October 14, 1993, Claimant filed a request for modification. (DX 1). Claimant's request was denied on June 15, 1995, by Administrative Law Judge Ainsworth H. Brown, who found that Claimant did not establish the existence of pneumoconiosis. *Id.* Claimant appealed, and the Board affirmed the administrative law judge's denial of Claimant's request for modification on November 30, 1995. *Id.* (citation omitted).

Claimant filed this second application for benefits on March 15, 2004. (DX 3). The District Director issued a Proposed Decision and Order awarding benefits on December 30, 2004. (DX 30). This matter was transferred to this office after Employer requested that a formal hearing be conducted by an Administrative Law Judge. (DX 31). Pursuant to a request by the Employer for a formal hearing conducted by an Administrative Law Judge, the claim was referred to the Office of Administrative Law Judges on November 21, 2005. (DX 36). A formal hearing in this matter was held on June 27, 2006, in Pikeville, Kentucky. All parties were afforded a full opportunity to present evidence as provided by the Act and the regulations issued thereunder. The Decision and Order which follows is based on all relevant evidence of record.

Length of Coal Mine Employment:

The duration of a coal miner's employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated to 33.5 years of coal mine employment. (TR 11-12). Based upon my full review of the record, including Administrative Law Judge Gilday's finding of 33.5 years of coal mine employment, which was affirmed by the Board, I accept the stipulation and credit Claimant with 33.5 years of coal mine employment, as that term is defined by the Act and Regulations. (DX 1-4). He last worked in the Nation's coal mines in 1985. (DX 2).

Dependency:

Claimant alleges one dependent for the purpose of benefit augmentation, namely his wife, M. C., whom he married on April 21, 1956. (DX 3). Claimant's marriage certificate was admitted into the record. (DX 12). Accordingly, I find that Claimant has one dependent for the purpose of benefit augmentation.

Timeliness:

Employer contests the timeliness of this claim on the basis that it was not filed within three years of Claimant being informed that he was disabled due to pneumoconiosis, as required under § 725.308. (TR 12; DX 36). The current claim was filed on March 15, 2004. (DX 2). Employer contends that Claimant became aware that he was totally disabled due to pneumoconiosis earlier than 1985, when he quit working as a coal miner. (Employer's closing brief, p. 8) Employer argues that Claimant admitted as much, when he testified at the hearing that he was first told that he was totally disabled due to pneumoconiosis, "[m]aybe sometime in the 80's." *Id.* He went on to state that he "quit working in '85, but just before that. '82, I believe it was." *Id.* Claimant did not recall who told him, but he knew that he had been told of his "lung problems" because he was often short of breath. (TR 34).

Claims for benefits under the Act are accorded a statutory presumption of timeliness. § 725.308(c). A claim is timely filed if it was filed before three years after a "medical determination of total disability due to pneumoconiosis" is communicated to the miner. § 725.308(a); 30 U.S.C. § 932(f). It is Employer's burden to rebut the presumption of timeliness by showing that a medical determination satisfying the statutory definition was communicated to the miner three years prior to the date of his subsequent filing. *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 607 (6th Cir. 2001). In this case, the date of Claimant's subsequent filing was March 15, 2004. In *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004)(unpub.), a case arising within the Sixth Circuit, the Board concluded that "the administrative law judge must determine if (the physician) rendered a well-reasoned diagnosis of disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

In *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), the court held that under § 725.308(a), the statute of limitations for filing starts after each denial of a previous claim, provided that the miner returns to coal mine employment for a substantial period of time after the denial and a new medical opinion of total disability due to pneumoconiosis is communicated. *Sharondale*, 42 F.3d at 996. The court declined to hold that the statute of limitations only applied to the filing of initial claims. *Id.* "[F]or the Act to recognize

serial applications on the one hand, while limiting to three years the time in which all applications must be filed, makes no sense." *Id.*

The Sixth Circuit further defined the application of § 725.308 in *Kirk*. The *Kirk* court held that:

> [t]he three-year statute of limitations clock begins to tick the *first time* that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of the miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination . . . and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period.

264 F.3d at 608. The Sixth Circuit stated that Kirk's three prior denials did not trigger the statute of limitations because they were premature filings, noting that previous medical opinions did not conclusively opine that Kirk was totally disabled due to pneumoconiosis. The Board has also addressed this issue, in *Bowling v. Whitaker Coal Corporation*, BRB No. 04-0651 and 04-0651 (April 14, 2005), when it remanded the claim for reconsideration of the timeliness issue, quoting the instruction in *Sharondale* that an Administrative Law Judge must decide whether the record contains a "medical determination of total disability due to pneumoconiosis which has been communicated to the miner."

In this case, Employer presents convincing evidence that Claimant believed he was totally disabled due to pneumoconiosis sometime in the 1980's. However, Employer has failed to meet the first prong of the two-part test under § 725.308, which requires that it present medically supported and reasoned opinions that establish Claimant was actually totally disabled due to pneumoconiosis at the time. Claimant's testimony was that a doctor "took him out" of work with Employer, but Claimant could

not recall the name of the doctor who made any such diagnosis. (TR 34). It is also unclear whether Claimant was ever actually informed by a physician that he was totally disabled due to pneumoconiosis, as he only remembered that he was short of breath at the time and was informed of his "breathing problems." *Id.* In support of its argument that this claim is untimely, Employer submitted the medical report of Dr. Page, dated November 13, 1985. (EX 2). However, Dr. Page did not consider Claimant's smoking history when making his determination that Claimant has pneumoconiosis. *Id.* In addition, Dr. Page did not expressly find Claimant to be totally disabled, and there is no evidence that any of Dr. Page's findings were communicated to Claimant. Furthermore, the medical documentation that is attached to Dr. Page's report is unreadable because of the poor quality of the photocopy. Accordingly, for any of the reasons discussed above, I find Dr. Page's report insufficient to rebut the presumption that this claim was timely filed.

Employer also submitted the medical reports and depositions of Drs. Myers and Clarke, and deposition of Dr. Penman. (EX 2). Dr. Myers made a diagnosis of pneumoconiosis, which he believed to be totally disabling; however, he testified that if asked by Claimant, he "would recommend against further exposure." *Id.* Thus, Dr. Myers' own testimony suggests that his diagnosis was never communicated directly to Claimant. In addition, Dr. Myer's report and deposition include no evidence of the objective testing, and are therefore not adequately documented to support a diagnosis of totally disabling pneumoconiosis. *Id.* Dr. Clarke's medical report and deposition testimony were nearly identical to those of Dr. Myers, and are equally insufficient to rebut the presumption of timeliness. Similarly, Dr. Penman never testified that he communicated a diagnosis of totally disabling pneumoconiosis to Claimant. Although not submitted by Employer for the purpose of determining the issue of timeliness, the other medical evidence of record is also insufficient to rebut the presumption that this claim was timely filed.

In considering this evidence pursuant to § 725.308, the Sixth Circuit's holding in *Kirk*, and the Board's decision in *Bowling,* I find that Employer has failed to satisfy the first requirement under § 725.308, that a reasoned, probative, documented, and written medical report record that Claimant was totally disabled due to pneumoconiosis. Therefore, because Employer did not offer any evidence that a well-reasoned and well-documented diagnosis of total disability due to pneumoconiosis was communicated to Claimant, I find that

Employer did not rebut the presumption that this claim was timely filed.

Applicable Regulations:

Claimant filed this claim on March 15, 2004. (DX 2). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. In addition, the Amendments to the Part 718 regulations, which became effective on January 19, 2001, are also applicable.

The 2001 Amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. §725.414(a)(2)(ii). Likewise, employers and the District Director are subject to similar limitations on affirmative and rebuttal evidence. § 725.414(a)(3).

Subsequent Claim:

Section 725.309(d) provides that a subsequent claim must be denied unless the Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. The applicable conditions of entitlement are limited to those conditions upon which the prior denial was based. §725.309(d)(2). If the Claimant establishes the existence of one of these conditions, he has demonstrated, as a matter of law, a material change. If he is successful in establishing a material change, then all of the record evidence must be reviewed to determine whether he is entitled to benefits.

Final adjudication of Claimant's previous claim occurred when the Board affirmed Administrative Law Judge Brown's denial

of Claimant's request for modification on November 30, 1995, as discussed above. (DX 1). The current claim was filed on March 15, 2004, more than one year after the prior denial, so that it cannot be construed as a modification proceeding pursuant to § 725.310(a). The previous claim was denied when it was determined that Claimant failed to establish any of the applicable conditions of entitlement; i.e., pneumoconiosis arising out of coal mine employment, total disability, and total disability due to pneumoconiosis. (DX 1). Accordingly, this claim must be denied unless Claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the final claim became final. § 725.309(d).

Pneumoconiosis (Newly Submitted Evidence):

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to § 718.202, the miner can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in §§ 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under § 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with § 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

Dr. Forehand, a B-reader,[5] interpreted an x-ray, dated November 14, 2001, as positive for pneumoconiosis with a 1/0

[5] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986).

profusion. (DX 15). Dr. Barrett, a Board-certified Radiologist and B-reader, re-read the x-ray for quality purposes only. (DX 16). Dr. Wheeler, a Board-certified Radiologist and a B-reader, interpreted the x-ray as negative for pneumoconiosis. (DX 29). Having taken into account the physician's qualifications, I find this x-ray negative for pneumoconiosis.

Dr. Baker, a B-reader, interpreted an x-ray, dated June 7, 2005, as positive for pneumoconiosis with a 1/0 profusion. (CX 1). Dr. Wheeler, a Board-certified Radiologist and a B-reader, interpreted the x-ray as negative for pneumoconiosis. (EX 4). Having taken into account the physician's qualifications, I find this x-ray negative for pneumoconiosis.

Dr. Dahhan, a B-reader, interpreted an October 9, 2004, x-ray, as negative for pneumoconiosis. (DX 28). No rebuttal evidence was offered regarding this x-ray; therefore, I find it negative for pneumoconiosis.

Dr. Fino, a B-reader, interpreted a November 5, 2004, x-ray, as negative for pneumoconiosis. (EX 1). No rebuttal evidence was offered regarding this x-ray; therefore, I find it negative for pneumoconiosis.

Ultimately, all four x-rays were interpreted as negative for pneumoconiosis. Accordingly, I rely on the negative readings by qualified physicians in finding that Claimant has not established the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, § 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

Under § 718.202(a)(4), the fourth and final method to establish pneumoconiosis, a determination of the disease may be

made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201, which provides the following definition of pneumoconiosis:

> (a) For purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical or "clinical" pneumoconiosis and statutory or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthra-cosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
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> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§ 718.201.

Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Field v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.* An unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). *See also Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986) (a report which is internally inconsistent and inadequately reasoned may be entitled to little probative value). However, it is noteworthy that, in *Drummond Coal Co. v. Freeman,* 17 F.3d 361 (11th Cir. 1994), the Eleventh Circuit held that an administrative law judge "need not . . . find that a medical opinion is either wholly reliable or wholly unreliable"; rather, the opinion may be divided into the relevant issues of entitlement to determine whether it is reasoned and documented with regard to any particular issue.

Dr. J. Randolph Forehand, Board-certified in Allergy and Immunology and Pediatrics and Board-eligible in Pediatric Pulmonary Medicine and a B-reader, examined Claimant on April 26, 2004. (DX 15). His complete medical workup included a chest x-ray, pulmonary function study, arterial blood gas analysis, and EKG. Dr. Forehand recorded that Claimant worked in coal mine employment for thirty-three and a half years. He noted that Claimant suffers from daily cough with dark brown sputum production, wheezing with exertion and at night, and has experienced dyspnea on exertion for the past ten years. He also noted that Claimant is unable to climb stairs, must sleep using two pillows due to his breathing trouble, and experiences chest pain when he is short of breath. A chest examination revealed wheezing and displaced breath sounds, and an EKG showed atrial fibrillation. Dr. Forehand interpreted Claimant's x-ray as positive for coal workers' pneumoconiosis, with a 1/0 profusion, although the same x-ray was re-read as negative by a dually-qualified physician. (DX 15, 29). Claimant's pulmonary function

study was qualifying and his arterial blood gas analysis was non-qualifying. (DX 15).

Dr. Forehand made the following diagnoses: 1) coal workers' pneumoconiosis – based on Claimant's x-ray, history of coal dust exposure, physical examination, and pulmonary function study; and 2) chronic bronchitis – based on Claimant's history and pulmonary function study. (DX 15). Dr. Forehand determined the etiology of his diagnoses to be Claimant's coal mine dust exposure and cigarette smoking. Dr. Forehand categorized Claimant's pulmonary impairment as "significant". *Id.* He stated that "insufficient residual ventilatory capacity remains to return to last coal mining job. Unable to work. Totally and permanently disabled." *Id.* Dr. Forehand also noted that the "pattern of respiratory impairment indicates that 75% to 80% of overall disability is due to cigarette smoking and that 20-25%, a substantial portion, is due to coal mine dust exposure." *Id.*

In a clarification response, dated August 11, 2004, Dr. Forehand reiterated his earlier findings, further explaining that Claimant's "chronic bronchitis was the result of and was significantly aggravated by his coal mine employment." (DX 17).

In *Cornett v. Benham Coal, Inc.*, the Sixth Circuit held that a physician's opinion that the claimant's "obstructive ventilatory defect could have been caused by either smoking or coal dust exposure" should be viewed under the circumstances of that case as "tantamount to a finding that both coal dust exposure and smoking were operative factors and that it was impossible to allocate blame between them." *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). The Court emphasized that such a finding was sufficient to establish that the claimant's pneumoconiosis arose out of his coal mine employment, stating that:

> [U]nder the statutory definition of pneumoconiosis, Cornett was not required to demonstrate that coal dust was the *only* cause of his current respiratory problems. He needed only show that he has a chronic respiratory and pulmonary impairment 'significantly related to, or substantially aggravated by, dust exposure in coal mine employment.'

Id. at 576 (citing § 718.201)(emphasis in original).

The Court went on to find that the Administrative Law Judge improperly discounted the physicians' opinions, and emphasized

that "accurately following the regulatory definition of pneumoconiosis cannot be grounds for rejecting a doctor's opinion." *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

Furthermore, in *Crockett Collieries, Inc. v. Barrett*, the Sixth Circuit affirmed an Administrative Law Judge's award of benefits. *Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring). In *Barrett*, both Drs. Baker and Dahhan concluded that the miner suffered from a respiratory impairment. *Id.* at 356. However, they disagreed as to whether the impairment "could all be due to cigarette smoking or could be due to a combination of cigarette smoking and coal dust exposure." *Id*. Dr. Baker concluded that coal dust exposure "probably contributes to some extent in an undefinable portion" to the miner's pulmonary impairment. *Id.* The Court agreed with the Administrative Law Judge's reasoning, holding that after invoking the rebuttable presumption that the miner's legal pneumoconiosis arose out of coal dust exposure at § 718.203(b), the Administrative Law Judge properly found Dr. Baker's opinion sufficient, and not too equivocal, to support a finding that the miner suffered from pneumoconiosis arising out of coal mine employment. *Id.* at 358; *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.)(holding that the Administrative Law Judge properly credited a physician's opinion, which stated that the claimant's pneumoconiosis was related to coal dust exposure, by considering other possible factors, such as smoking, age, obesity, or hypertension.).

In this case, Dr. Forehand diagnosed clinical and legal pneumoconiosis, and unequivocally found that both diagnoses were causally related to dust exposure and cigarette smoking. (DX 15; 17). In forming his opinion, Dr. Forehand relied on Claimant's physical exam, chest x-ray, qualifying pulmonary function test, and history. In *Church v. Eastern Assoc. Coal Corp.*, 21 B.L.R. 1-51 (1997), *rev'g in part and aff'g in part on recon.*, 20 B.L.R. 1-8 (1996), the Board reaffirmed its earlier holding that the administrative law judge properly analyzed the medical evidence under § 718.202(a)(4) in crediting the physicians' opinions that were supported by underlying objective studies. Moreover, the Board reiterated that "an administrative law judge may not discredit an opinion solely on the ground that it is based, in part, upon an x-ray reading which is at odds with the administrative law judge's finding with respect to the x-ray evidence of record.' In so holding, the Board noted that the physician also based his finding on observations gathered during the time he physically examined Claimant.

In addition, a finding of pneumoconiosis under § 718.202(a)(4) "shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories." § 718.202(a)(4). Dr. Forehand expressly stated that he based Claimant's clinical and legal pneumoconiosis diagnoses on objective medical evidence, other than the x-ray that was interpreted as negative by a higher qualified physician, including Claimant's history, physical examination, and pulmonary function study. Therefore, I find Dr. Forehand's report well-reasoned and well-documented as to both clinical and legal pneumoconiosis.

Dr. Glen Baker, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, physically examined Claimant on June 7, 2005. (CX 1). His medical workup included a chest x-ray, pulmonary function test, and an arterial blood gas study. Dr. Baker recorded that Claimant worked a total of thirty-three and a half years in coal mine employment and smoked off and on for 15-20 years, at a rate of one-half to one pack of cigarettes a day from the 1960's to the 1980's. He stated that Claimant suffers from daily cough with sputum production, daily wheezing, daily dyspnea, occasional chest pain, orthopnea – which is aided by the use of two to three pillows, and ankle edema. Claimant's chest examination revealed severe bilateral inspiratory and expiratory wheezing. Under x-ray findings, Dr. Baker noted coal workers' pneumoconiosis, with a 1/0 profusion, although this x-ray was reread as negative by Dr. Wheeler. (CX 1; EX 4). His pulmonary function study was qualifying and revealed a "severe obstructive defect." (CX 1). The administering technician noted fair effort, and commented that Claimant experienced "severe shortness of breath." *Id.* She determined, however, that Claimant "appeared to do the best he could." *Id.* The arterial blood gas analysis was non-qualifying, but showed "mild resting arterial hypoxemia." *Id.*

Dr. Baker made the following diagnoses: 1) coal workers' pneumoconiosis 1/0 – based on an abnormal x-ray and coal dust exposure; 2) COPD (chronic obstructive pulmonary disease) with severe obstructive defect – based on pulmonary function tests; 3) chronic bronchitis - based on history; and 4) hypoxemia — based on results of arterial blood gas analysis. Dr. Baker opined that Claimant had a severe impairment with decreased FEV_1, decreased PO_2, chronic bronchitis, and Coal Workers' Pneumoconiosis. Dr. Baker also noted that Claimant had cancer of the colon in the past. He concluded that Claimant's coal

workers' pneumoconiosis was caused by coal dust exposure, while his COPD, chronic bronchitis, and hypoxemia were caused by both coal dust exposure and cigarette smoking.

A diagnosis of pneumoconiosis based on a positive chest x-ray and history of dust exposure alone is not a well-documented and reasoned opinion. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). The Benefits Review Board permits discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113 (1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-1405 (1985)). Acknowledging that Dr. Baker performed other physical and objective testing, he listed that he expressly relied on Claimant's positive x-ray and coal dust exposure for his clinical determination of pneumoconiosis. However, the x-ray he relied upon was re-read as negative by a higher qualified physician. Moreover, he failed to state how results from his other objective testing might have impacted his diagnosis of clinical pneumoconiosis. As Dr. Baker does not indicate any other reasons for his diagnosis of clinical pneumoconiosis beyond the x-ray and exposure history, I find his diagnosis of clinical pneumoconiosis is neither well-documented nor well-reasoned.

Dr. Baker's diagnosis of hypoxemia was based on Claimant's non-qualifying blood gas analysis. He noted that the etiology of Claimant's hypoxemia was coal dust exposure and cigarette smoking. (CX 1). Legal pneumoconiosis is defined as any chronic lung disease or impairment arising out of coal mine employment. § 718.201(a). Accordingly, Dr. Baker's diagnosis of hypoxemia is inadequate to constitute legal pneumoconiosis under the regulations.

As discussed, legal pneumoconiosis includes any chronic lung disease or impairment arising out of coal mine employment. Dr. Baker diagnosed Claimant with COPD and chronic bronchitis, or legal pneumoconiosis, based on the qualifying results of a pulmonary function study. In the addendum to his medical report, Dr. Baker further explained how his consideration of Claimant's history of symptoms, occupational history, smoking history, physical examination, and the results of his objective medical testing support his finding that Claimant's COPD is related to coal dust exposure and cigarette smoking. *Id.*

For the reasons discussed above, I find Dr. Baker's opinion regarding legal pneumoconiosis to be well-reasoned and well-

documented. *See Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring); *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000); *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.).

Also, Dr. Baker opined that Claimant suffers from a severe pulmonary impairment. (CX 1). He stated that Claimant "would be unable to do the work of a coal miner or comparable work in a dust free environment...." *Id.* In addition, Dr. Baker concluded that Claimant's totally disabling impairment primarily related to "pneumoconiosis but there may be some minor contribution from his cigarette smoking history if it is greater than 15-pack years." *Id.* As discussed, I have found that Claimant has fifteen to twenty pack-years of smoking history. Dr. Baker's diagnosis and reasoning are based on his assumption of fifteen years. Furthermore, his diagnoses are strengthened by his consideration of the objective medical evidence should it be determined that Claimant smoked for a longer period of time. Accordingly, I find Dr. Baker's opinion that Claimant is totally disabled due to pneumoconiosis well-documented and well-reasoned.

Dr. D. Stamper, Jr., Claimant's treating physician since 1978, completed a medical questionnaire, dated July 14, 2004. (DX 13). Dr. Stamper diagnosed Claimant with advanced COPD, which he concluded was aggravated by coal dust exposure from working in the coal mines. As discussed, this diagnosis constitutes a finding of legal pneumoconiosis under the regulations. § 718.201(a)(2). Dr. Stamper also noted that Claimant has chronic bronchitis, asthma, and emphysema, but did not expressly relate those diagnoses to coal mine employment. Dr. Stamper also reported that he prescribed home oxygen for Claimant's hypoxemia. In addition, he opined that Claimant is totally disabled due to his advanced COPD.

When assigning weight to the opinion of a treating physician, the regulations give the following guidance:

> In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

§ 718.104(d)(5). Although he has been Claimant's treating physician for twenty-nine years, which may have entitled his opinion to additional weight if it were supported by a reasoned and documented report, Dr. Stamper failed to provide any objective data to support his opinion. Furthermore, he expressed no reasoning for his diagnoses. Thus, I find his opinion regarding legal pneumoconiosis unreasoned and undocumented and give it little weight.

Dr. A. Dahhan, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, examined Claimant on October 18, 2004. (DX 28). His complete medical workup included a chest x-ray, pulmonary function study, arterial blood gas analysis, and EKG. Dr. Dahhan recorded that Claimant worked in the coal mining industry for thirty-three years ending in 1985 because of ear problems. He reported that Claimant used to smoke an average of one-half to one pack of cigarettes a day, beginning at age sixteen and quitting at the age of fifty. He noted that Claimant has a history of daily cough with productive clear sputum and intermittent wheeze, dyspnea on exertion, and intermittent chest pain. Claimant sleeps with three pillows. Dr. Dahhan also reported that Claimant is prescribed several medications for his respiratory problems, and is on oxygen as needed. He noted that Claimant has a history of diabetes mellitus, occasional back pain, four ear surgeries, and that he had cancer of the colon eight years earlier. A chest examination showed "increased AP diameter with hyper resonance to percussion." *Id.* Auscultation revealed "reduced air entry to both lungs with diffused expiratory wheeze and marked prolongation of the expiratory phase." *Id.* The EKG showed "irregular tachycardia compatible with fibrillation with fast ventricular rate and PVCs." *Id.* Dr. Dahhan interpreted an x-ray as negative for coal workers' pneumoconiosis, but noted that it showed "hyperinflated lungs consistent with emphysema and elevated left hemi diaphragm." *Id.* Claimant's pulmonary function study was qualifying both before and after the administration of bronchodilators. His arterial blood gas analysis was non-qualifying.

Based on the occupational, clinical, radiological, and physiological evaluation, Dr. Dahhan made the following findings:

> 1. There are insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis based on the obstructive abnormalities on clinical examination of

the chest, obstructive abnormality on pulmonary function studies and negative x-ray reading for pneumoconiosis.

2. [Claimant] has severe chronic obstructive lung disease.

3. Overall, from a respiratory standpoint, [Claimant] does not retain the physiological capacity to continue his previous coal mining work or job of comparable physical demand.

4. [Claimant's] obstructive ventilatory defect and pulmonary disability has resulted from his lengthy smoking habit and possibly contributed to by an asthmatic condition.

5. [Claimant's] pulmonary disability was not caused by, related to, contributed to or aggravated by the inhalation of coal dust since 1985, a duration or absence sufficient to cause cessation of any industrial bronchitis that he may have had. Furthermore, his airway obstruction demonstrates significant response to bronchodilator therapy despite already being on multiple bronchodilator medication and his airway obstruction is severe and disabling in nature, a finding that is not seen secondary to the inhalation of coal dust.

6. [Claimant] has non-insulin dependent diabetes, hypertension, atrial fibrillation, and cancer of the colon. All are conditions of the general public at large and are not caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis.

(DX 28).

Based on the obstructive nature of Claimant's respiratory problems and a negative x-ray, Dr. Dahhan opined that Claimant does not have clinical pneumoconiosis.

In *Freeman United Coal Mining Co. v. Summers*, the Seventh Circuit concluded that the administrative law judge properly gave less weight to the opinion of a physician "based on a finding that they were not supported by adequate data or sound analysis." *Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473 (7th Cir. 2001). Importantly, the Court made reference to the comments to the amended regulations and stated the following:

> Dr. Fino stated in his written report of August 30, 1998 that 'there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease.' (citation omitted). During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'

Id. at n. 7.

Dr. Dahhan makes similar assertions in this case, having partially based his finding that Claimant does not have clinical pneumoconiosis on the obstructive nature of Claimant's impairment.

After discounting this reasoning, Dr. Dahhan's remaining reason for his finding that Claimant does not have clinical pneumoconiosis is his positive x-ray reading. In *Mountain Clay Coal Co. v. Spivey,* the Sixth Circuit affirmed the holding of the Board, which affirmed the Administrative Law Judge's decision that discounted the opinions of two physicians who had relied solely on negative x-ray readings in determining that the claimant did not have pneumoconiosis. *Mountain Clay Coal Co. v. Spivey,* 172 Fed.Appx. 641, 645 (6th Cir. 2006) (unpub.) (citing *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000) (agreeing that restatement of x-ray does not constitute reasoned medical judgment); and § 718.202(b) ("No claim for benefits shall be denied solely on the basis of a negative chest x-ray.").

Therefore, because the view that coal dust exposure cannot cause an obstructive pulmonary abnormality is not in accord with the general standpoint of the medical and scientific communities, and because Dr. Dahhan's determination that Claimant does not have clinical coal workers' pneumoconiosis is otherwise based solely on his negative x-ray reading, Dr. Dahhan's reasoning is insufficient to support his opinion as to a diagnosis of no clinical pneumoconiosis. Therefore, I grant Dr. Dahhan's opinion regarding clinical pneumoconiosis little probative weight.

Dr. Dahhan's diagnosis of COPD would constitute a find of legal pneumoconiosis under the regulations if Dr. Dahhan had related Claimant's COPD to his coal mine employment. § 718.201(a)(2). However, for the reasons outlined above, Dr. Dahhan determined that Claimant's COPD could not have arisen out of his coal mine employment. In *Consolidation Coal Co. v. Swiger*, the Fourth Circuit Court of Appeals upheld an Administrative Law Judge's finding that the reversibility of pulmonary function values after use of a bronchodilator does not preclude the presence of disabling coal workers' pneumoconiosis. *Consolidation Coal Co. v. Swiger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.). In particular, the court noted the following:

> All the experts agree that pneumoconiosis is a fixed condition and therefore any lung impairment caused by coal dust would not be susceptible to bronchodilator therapy. In this case, although Swiger's condition improved when given a bronchodilator, the fact that he experienced a disabling residual impairment suggested that a combination of factors was causing his pulmonary condition. As a trier of fact, the ALJ 'must evaluate the evidence, weigh it, and draw his own conclusions.' (citation omitted). Therefore, the ALJ could rightfully conclude that the presence of the residual fully disabling impairment suggested that coal mine dust was a contributing cause of Swiger's condition. (citation omitted).

Id.

In this case, Dr. Dahhan relies on the improvement in Claimant's pulmonary function results after the administration of a bronchodilator in determining that Claimant's impairment is related solely to his smoking history. However, Dr. Dahhan fails

to consider that Claimant's post-bronchodilator still produced qualifying results.

In addition, in *Cannelton Industries, Inc. v. Frye,* the Forth Circuit concluded that the ALJ properly accorded less weight to the opinion of Dr. Forehand, who found that the miner was totally disabled due to smoking-induced bronchitis, but failed to explain "how he eliminated (the miner's) nearly thirty years of exposure to coal mine dust as a possible cause" of the bronchitis. In affirming the ALJ, the court noted that "Dr. Forehand erred by assuming that the negative x-rays (underlying his opinion) necessarily ruled out that (the miner's) bronchitis was caused by coal mine dust ...." *Cannelton Industries, Inc. v. Frye,* Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub.).

Moreover, in *Crockett Collieries, Inc. v. Barrett*, the Sixth Circuit Court of Appeals agreed with the administrative law judge's weighing of the medical evidence and affirmed the claimant's award of benefits, noting that:

> In rejecting Dr. Dahhan's opinion, the ALJ found that Dahhan had not adequately explained why Barrett's responsiveness to treatment with bronchodilators necessarily eliminated a finding of legal pneumoconiosis, and had not adequately explained 'why he believes that coal dust exposure did not exacerbate (the miner's) allegedly smoking-related impairments.'

Crockett Collieries, Inc. v. Barrett, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring); *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.).

In the present case, Dr. Dahhan similarly failed to sufficiently explain the significance of Claimant's responsiveness to bronchodilators, particularly because Claimant's improved results are still qualifying under the regulations. Additionally, Dr. Dahhan did not adequately explain why he believes that coal dust exposure did not contribute to Claimant's impairment. Instead he chose to rely solely on smoking history, apparently without considering whether both cigarette smoking and coal dust exposure had a concurrent effect in causing chronic obstructive lung disease. For the reasons stated above, I find Dr. Dahhan's opinion regarding legal pneumoconiosis insufficiently reasoned and I grant it little probative weight.

Dr. Gregory Fino, Board-certified in Internal Medicine and Pulmonary Diseases and a B-reader, examined Claimant on November 5, 2004. (EX 1). His complete medical workup included a chest x-ray, pulmonary function study, and arterial blood gas analysis. Dr. Fino recorded that Claimant worked in the coal mine industry for thirty-four years, last working as a coal truck driver on a strip mine, which included some heavy labor. He left the mines in 1985 because of breathing problems and no longer works. Dr. Fino reported that Claimant smoked one pack of cigarettes a day for forty-one years, from 1943 until 1984. He recorded that Claimant has suffered shortness of breath for the past twenty-five years that is getting worse, but that it does not interfere with his usual daily activities; however, without explanation, Dr. Fino also recorded that Claimant "is limited in what he can do because of his breathing." *Id.* He also noted that Claimant suffers from dyspnea when walking at his own pace on level ground or ascending up one flight of stairs. Dyspnea also occurs when Claimant is walking up hills or grades, lifting and carrying, performing manual labor, and walking briskly on level ground. Claimant complained of daily cough, with sputum production, daily wheezing, and chest pain. A chest examination revealed diffuse bilateral wheezing. Dr. Fino interpreted the chest x-ray as negative for pneumoconiosis. Claimant's pulmonary function study was qualifying, both before and after the administration of bronchodilators. The resting arterial blood gas analysis was non-qualifying, but minimal hypoxemia and moderate hypercarbia were noted. Dr. Fino also considered the medical report and clarification letter of Dr. Forehand and the physician's questionnaire completed by Dr. Stamper described above.[6] Dr. Fino diagnosed Claimant with severe COPD with fixed and reversible obstructive bronchitis and emphysema caused by cigarette smoking. He based his diagnosis on his review of the x-rays, his own negative x-ray, the obstructive nature of Claimant's impairment and his improvement following the use of bronchodilators, a reduction in diffusing capacity consistent with emphysema due to cigarette smoking, and no reduction in total lung capacity, which Dr. Fino stated rules out restrictive lung disease and pulmonary fibrosis. Dr. Fino determined that

[6] Employer also submitted a second report by Dr. Fino (EX 3), dated June 15, 2006, which was designated by Employer as rebuttal to Dr. Baker's report (CX 1), which was dated June 7, 2005. Claimant objected to EX 3, arguing that the regulations do not provide for the rebuttal of medical reports. Claimant's argument is correct and his objection is sustained. Dr. Fino's June 15, 2006, report is excluded from consideration. *See* § 718.414(a)(3)(ii). Even if Dr. Fino's June 15, 2006, report had been considered, the outcome of this case would not change, because Claimant would still prove all of the elements of entitlement by a preponderance of the evidence, for the reasons discussed herein.

Claimant is unable to return to his former coal mine employment. He lists cigarette smoking and coal dust exposure as two risk factors for Claimant's disability. However, Dr. Fino stated that even assuming that COPD due to coal mine employment contributed to Claimant's obstruction, compensation for the loss in FEV_1 associated with coal dust exposure would not eliminate Claimant's disability, as "[t]his man would be as disabled had he never stepped foot in the mines." (DX 16).

As previously discussed, a finding of no clinical pneumoconiosis based solely on a negative x-ray is not a well-reasoned and documented opinion. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000) (agreeing that restatement of x-ray does not constitute reasoned medical judgment). However, Dr. Fino's diagnosis of no clinical pneumoconiosis was based on his own medical evidence and the review of the medical evidence of record; therefore, I find this portion of his medical report well-reasoned and well-documented.

Dr. Fino also diagnosed severe COPD, but for the reasons outlined above, he related Claimant's condition solely to cigarette smoking. As discussed *supra*, the Seventh Circuit concluded that the administrative law judge properly gave less weight to the opinions of a physician, "based on a finding that they were not supported by adequate data or sound analysis." *Freeman United Coal Mining Co. v. Summers*, 272 F.3d 473 (7th Cir. 2001). Importantly, the Court made reference to the comments to the amended regulations and stated the following:

> Dr. Fino stated in his written report of August 30, 1998 that 'there is no good clinical evidence in the medical literature that coal dust inhalation in and of itself causes significant obstructive lung disease.' (citation omitted). During a rulemaking proceeding, the Department of Labor considered a similar presentation by Dr. Fino and concluded that his opinions 'are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature.'

Id. at n. 7.

Dr. Fino makes similar assertions in this case, having stated in his report that "[t]he medical literature does not provide clinical evidence that coal mine dust inhalation, in and of itself, causes significant obstructive lung disease irrespective of its ability to be reversed following

bronchodilators." (EX 1). Dr. Fino concluded that Claimant's obstructive impairment is "consistent with smoking." *Id.* Because this view is not in accord with the general standpoint of the medical and scientific communities, Dr. Fino's reasoning is insufficient to support his opinion that Claimant's condition is not related to coal mine employment.

In addition, Dr. Fino's reliance on Claimant's improvement in pulmonary function tests post-bronchodilator is unreasoned, as discussed above in regards to Dr. Dahhan's report. Dr. Fino does not account for the fact that both cigarette smoking and coal dust exposure could have played a part in Claimant's condition. Reversibility of pulmonary function is not necessarily an indication that a coal dust-related impairment does not exist, particularly when Claimant's tests continue to produce qualifying results post-bronchodilator. See *Crockett Collieries, Inc. v. Director, OWCP [Barrett]*, ___ F.3d ___, 2007 WL 494664, Case No. 05-4188 (6th Cir. Feb. 16, 2007); *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000); *Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.); *see also Consolidation Coal Co. v. Swiger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.).

Moreover, Dr. Fino stated in his report that Claimant's shortness of breath "does not interfere with his usual daily activities." (CX 1). However, without any explanation, Dr. Fino also recorded in his report, just one paragraph later, that Claimant "is limited in what he can do because of his breathing." *Id.* It is proper to accord little probative value to a physician's opinion which is inconsistent with his or her earlier report or testimony. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984) (a failure to explain inconsistencies between two reports which were eight months apart rendered the physician's conclusions of little probative value); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984) (physician's report discredited where he found total disability in a earlier report and then, without explanation, found no total disability in a report issued five years later). *See also Brazzale v. Director, OWCP,* 803 F.2d 934 (8th Cir. 1986) (a physician's opinion may be found unreasoned given inconsistencies in the physician's testimony and other conflicting opinions of record). Accordingly, I find Dr. Fino's report equivocal and internally inconsistent.

Furthermore, Dr. Fino determination that smoking was the only cause of Claimant's respiratory problems is not supported by the evidence in this case. Dr. Fino reported that Claimant

has a forty-one year smoking history starting in 1943, at the age of ten or eleven, and ending in 1984. However, as discussed herein, I have found that Claimant has a fifteen to twenty pack-year smoking history based on the preponderance of the evidence. Dr. Fino's determination that Claimant's respiratory problems are related solely to smoking is based on a legally inaccurate determination of Claimant's smoking history.

Accordingly, for any of the reasons stated above, I find Dr. Fino's opinion regarding the etiology of Claimant's COPD is insufficiently reasoned. Therefore, I give his opinion little probative weight on the issue of legal pneumoconiosis.

I find Dr. Forehand's opinion well-documented and well-reasoned as to his findings of both clinical and legal pneumoconiosis. I also find Dr. Baker's finding of legal pneumoconiosis well-documented and well-reasoned. In addition, I find Dr. Fino's finding that Claimant does not have clinical pneumoconiosis well-documented and well-reasoned. Weighing the probative newly submitted evidence together, I find that Claimant has established, by a preponderance of the evidence, the existence of legal pneumoconiosis per § 718.202(a)(4).

In sum, I find that Claimant has not proved the existence of pneumoconiosis pursuant to § 718.202(a)(1-3), but has proved the existence of legal pneumoconiosis pursuant to § 718.202(a)(4). Therefore, as Claimant has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the previous claim became final, the entire record must be reviewed and considered to determine whether Claimant is entitled to benefits under the Act. § 725.309.

Pneumoconiosis (Full Review):

Claimant's reviewable previous claim was filed in 1987 (DX 1, 3). The medical evidence in the first claim is dated prior to 1988. The Board has held that it is proper to afford the results of recent medical testing more weight than earlier testing. *See Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); *Schretroma v. Director, OWCP*, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the medical evidence in Claimant's first claim is

more than eleven years older than the newly submitted evidence (DX 1), I grant greater weight to the more recent medical evidence in determining whether the applicable conditions of entitlement have been established in this case.

Accordingly, I find that Claimant has established the existence of legal pneumoconiosis, for the reasons discussed above.

Causation of Pneumoconiosis:

Once it is determined that a claimant suffers from pneumoconiosis, it must be determined whether Claimant's pneumoconiosis arose, at least in part, out of coal mine employment. § 718.203(a). The burden is upon Claimant to demonstrate by a preponderance of the evidence that his or her pneumoconiosis arose out of coal mine employment. The regulations provide the following presumption in certain cases:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arouse out of such employment.

§ 718.203(b).

Based on the evidence of record, Claimant has established legal pneumoconiosis and that he worked in the coal mines for at thirty-three and a half years. As Employer's evidence is insufficient to rebut the presumption, for the reasons previously discussed, Claimant has established that his pneumoconiosis arose out of his coal mine employment.

Total Disability (Full review):

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his usual coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2), or the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987).7 Furthermore, Claimant must establish total disability by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986).

Section 718.204(b)(2)(i) provides for a finding of total disability where pulmonary function tests demonstrate FEV_1[8] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[9] or MVV[10] values equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2) and Appendix B. Four newly submitted pulmonary function studies, dated April 26, 2004, October 9, 2004, November 5, 2004, and June 7, 2005, have been entered into the record and are all qualifying, both before and after the administration of bronchodilators. (DX 15, 28; CX 1; EX 1). Because the evidence submitted as part of Claimant's initial claim is more than eleven years older than the newly submitted evidence, I rely on the more recent pulmonary function studies. Thus, I find the pulmonary function study evidence of record establishes total disability pursuant to § 718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO_2 to pO_2,

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[7] The Sixth Circuit has stated that any one of regulatory methods is sufficient to establish total disability. *Crockett Colleries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007).

[8] Forced expiratory volume in one second.

[9] Forced vital capacity.

[10] Maximum voluntary ventilation.

which indicates the presence of a totally disabling impairment in the transfer of oxygen from Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following § 718 of the regulations. Four newly submitted arterial blood gas studies, dated April 26, 2004, October 9, 2004, November 5, 2004, and June 7, 2005, have been entered into the record and are all non-qualifying. (DX 15, 28; CX 1; EX 1). Because the evidence submitted as part of Claimant's previous claim is more than eleven years older than the newly submitted evidence of record, I rely on the more recent arterial blood gas analyses. Thus, I find the arterial blood gas evidence of record does not establish total disability pursuant to § 718.204(b)(2)(i).

Total disability under § 718.204(b)(2)(iii) is inapplicable in this case, because Claimant failed to present any evidence of cor pulmonale with right-sided congestive heart failure.

Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(2)(iii), § 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful work.

In Claimant's current claim, I find that Dr. Stamper's assessment of Claimant's total disability is not supported by objective evidence. (DX 13). However, Drs. Forehand, Baker, Dahhan, and Fino all found, based on objective data, that Claimant is totally disabled due to his pulmonary impairment. (DX 15, 28; CX 1; EX 1). I continue to grant more probative value to the more recent probative evidence from Claimant's current claim and less weight to the older evidence from Claimant's previous claim. Therefore, I find that Claimant has established total disability pursuant to § 718.204(b)(2)(iv).

In sum, after reviewing the more recent probative evidence of record, I find that Claimant has established total disability pursuant to § 718.204. I rely on the qualifying pulmonary function studies and the physicians' findings, as discussed.

Total Disability Due to Pneumoconiosis:

The regulations state that a claimant "shall be considered totally disabled due to pneumoconiosis if pneumoconiosis ... is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." § 718.204(c)(1). Pneumoconiosis is considered a "substantially contributing cause" of the claimant's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204(c)(1).

In interpreting this requirement, the United States Court of Appeals for the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). Claimant must prove total disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2).

Drs. Baker and Forehand both opined that Claimant is totally disabled due to pneumoconiosis.[11] As discussed above, I have found both opinions well-reasoned and well-documented on the issues of legal pneumoconiosis and total disability. As their opinions are based on objective medical testing and their personal evaluations of Claimant and his medical and occupational histories, I also find their opinions are well-documented and well-reasoned on the issue of total disability due to pneumoconiosis.

I have found Dr. Stamper's overall opinion neither well-reasoned nor well-documented. In addition, I have found the reports of Drs. Dahhan and Fino are not well-reasoned as to the existence of legal pneumoconiosis, for the reasons stated above, while I have found their opinions well-reasoned as to their diagnoses of total disability.

[11] Dr. Stamper also found that Claimant is totally disabled due to pneumoconiosis; however, his opinions regarding both pneumoconiosis and total disability are not well-reasoned and well-documented, for the reasons discussed herein.

The Board has held that it was proper for an administrative law judge to accord less weight to physicians' opinions, which concluded that pneumoconiosis did not contribute to the miner's disability, on grounds that the physicians did not diagnose pneumoconiosis. *See Osborne v. Clinchfield Coal Co.*, BRB No. 96-1523 BLA (Apr. 30, 1998) (*en banc on recon.*)(unpub.). Accordingly, I find Dr. Dahhan's and Dr. Fino's medical reports unreasoned as to total disability due to pneumoconiosis and give them little weight.

I continue to rely on the more recent probative evidence from Claimant's current claim. Therefore, based on the well-reasoned and well-documented reports of Drs. Forehand and Baker, I find that Claimant has established total disability due to pneumoconiosis.

Entitlement:

As Claimant has established pneumoconiosis arising out of coal mine employment and total disability due to pneumoconiosis, he is entitled to benefits under the Act.

Date of Entitlement:

Section 725.503 provides that benefits are payable to a miner who is entitled beginning with the month of the onset of total disability due to pneumoconiosis. Where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed.

The record in this case does not contain any medical evidence establishing exactly when Claimant became totally disabled. Therefore, payment of benefits is established as of March 2004, the month and year in which the Claimant filed this claim for benefits.

Attorney's Fees:

No award of attorney's fees for service to Claimant is made herein because no application has been received from counsel. A period of thirty (30) days is hereby allowed for the Claimant's counsel to submit an application. *Bankes v. Director,* 8 BLR 2-1 (1985). The application must conform to §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties,

including Claimant and Solicitor as counsel for the Director. Parties so served shall have twenty (20) days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge Claimant any fee in the absence of the approval of such application.

ORDER

It is HEREBY ORDERED that

1. The claim of B. B. for benefits under the Act is hereby GRANTED;

2. Ratliff & Childers Coal Corp., as insured by Liberty Mutual Insurance Co., shall pay B. B. all benefits to which he is entitled to under the Act;

3. Ratliff & Childers Coal Corp., as insured by Liberty Mutual Insurance Co., shall refund to the Black Lung Disability Trust Fund all benefits, plus interest, if previously paid on behalf of Ratliff & Childers Coal Corp.; and,

4. Ratliff & Childers Coal Corp., as insured by Liberty Mutual Insurance Co., shall pay Claimant's attorney, Stephen A. Sanders, Esq., fees and expenses to be established in a supplemental decision and order.

A

LARRY S. MERCK
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the District Director's office. *See* §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing

date, may be used. *See* § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to § 725.479(a).